

**Ohio Department of Health • School and Adolescent Health**

# Physical Examination

|                |        |  |                      |
|----------------|--------|--|----------------------|
| Student's name |        | Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth<br>/ / |
| Height         | Weight | BMI percentile   | BP                   |

**Screening Tests**

| Vision  | Hearing   | Postural  |
|---|---|---|
| Date performed<br>/ /   | Date performed<br>/ /   | Date performed<br>/ /   |
| Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L<br>Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail<br>Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail<br>Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail<br>Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No | Pure Tone<br>Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail<br>Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail<br>Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> No abnormality noted<br><input type="checkbox"/> Screening not done<br><input type="checkbox"/> Referral made<br>Comments<br>_____<br>_____<br>_____ |

**Speech/Language**

Speech assessment completed     Yes     No  
 Child has no discernible speech problem     Yes     No  
 Speech evaluation recommended     Yes     No  
 Child has possible problem with \_\_\_\_\_

**Lead Poisoning**

Date \_\_\_\_\_ Type  C    V   Results \_\_\_\_\_ µg/dL  
 Date \_\_\_\_\_ Type  C    V   Results \_\_\_\_\_ µg/dL

**Tuberculin Test**  
 Date \_\_\_\_\_ Type \_\_\_\_\_ Results \_\_\_\_\_

**Health History** (Serious or chronic illnesses/injuries/surgeries)

\_\_\_\_\_

**Physical Examination** Date of most recent examination / /

Essentially normal     Abnormalities as follows

\_\_\_\_\_

Is this child able to participate fully in:

|                                   |  |                              |  |
|-----------------------------------|--|------------------------------|--|
| Classroom and academic activities | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical education classes   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Competition athletics             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact and collision sports | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If limitations are advised, please specify

\_\_\_\_\_

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

\_\_\_\_\_

|                                 |            |                 |
|---------------------------------|------------|-----------------|
| HealthCare Provider's signature | Print name | Phone<br>(    ) |
| Address                         |            | Date<br>/ /     |
| City                            | State      | ZIP             |